

**Assessing the Performance of Family Planning Service
at the Primary Care Level in Nigerian Local
Government Area Health Centers and NGO Clinics**

Final Report

January 2001

Performance Needs Assessment Team

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EXECUTIVE SUMMARY

During the years 1992-1998, the years of military dictatorship, the health sector in Nigeria experienced neglect. This neglect shows in the decline in overall health statistics in the country. Likewise, family planning services have seen a decline, with the anticipated slide in family planning statistics such as fertility rate and maternal mortality. During the period since the return of democracy, USAID has played an instrumental role in strengthening the general health sector. With the effects of HIV/AIDS strongly felt in Nigeria, USAID rightly prioritized early efforts in the HIV/AIDS sector. With those efforts showing promise and progress, USAID is now planning to re-emphasize its commitment to Family Planning and Reproductive Health (FP/RH) in Nigeria.

In early 2001, USAID Nigeria will formulate and disseminate its plan to strengthen FP/RH in the near- and mid-term. In order to make an effective plan, USAID Nigeria, in concert with USAID Washington, is gathering information about the current status of FP/RH in Nigeria, as well as the needs of the FP/RH service provider network. The Nigeria Performance Needs Assessment team described in this report will provide one input, one source of information to be used by USAID for better decision making.

In December of 2000, a six-member team made up of staff from 5 USAID Cooperating Agencies (CAs) visited Nigeria to answer three questions about the state of FP/RH services:

1. What is the desired performance of clinics and providers?
2. Compared to that standard, what is the actual performance of clinics and providers?
3. Where there are gaps between desired and actual performance, what are the causes; what do clinics and providers need to perform better?

The team's focus was the primary service delivery site, both Public and NGO. Partnering with Federal and State Ministry of Health staff members, teams visited the three representative states of Oyo, Enugu, and Bauchi. There they conducted stakeholder meetings, focus group discussions, and made site observation visits, in order to answer the three questions above. (The methodology is based on the USAID Performance Improvement Consultative Group's *Performance Improvement Approach*.)

The team found that there are significant gaps between client and community desired performance of clinics and providers, and actual performance. Clinics have high-priority performance gaps in the areas of service availability, commodity availability, management systems, and clinic cleanliness. Providers have high-priority performance gaps especially in the areas of interpersonal skills, FP counseling procedures, infection prevention procedures, and record keeping.

Next steps will include site return visits by USAID staff to finalize plans for interventions to close these important performance gaps. Interventions will be deployed during the latter half of 2001.

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ABBREVIATIONS

USAID.....	United States Agency for International Development
HIV	Human Immunodeficiency Virus
AIDS.....	Acquired Immunodeficiency Syndrome
FP.....	Family Planning
RH.....	Reproductive Health
CA.....	(USAID) Cooperating Agency
NGO	Non-governmental Organization
PPFN	Planned Parenthood Federation of Nigeria
UNFPA	United Nations Family Planning Association
CEDPA.....	Center for Development Population Activities
JHU	Johns Hopkins University
CPR.....	Contraceptive prevalence rate
TFR	Total fertility rate
MMR	Maternal mortality rates
UNAIDS.....	United Nations AIDS
PNA.....	Performance Needs Assessment
FMOH	Federal Ministry of Health
SMOH	State Ministry of Health
NMOH.....	Nigeria (Federal) Ministry of Health
LGA	Local Government Area
DFID.....	Department for International Development
GPRA	Government Performance and Results Act
TRG	Training Resources Group, Inc.
MSH	Management Sciences for Health
PICG.....	(USAID) Performance Improvement Consultative Group
PI.....	Performance Improvement
PIA.....	Performance Improvement Approach
FGD	Focus Group Discussion
ARFH	Association for Reproductive and Family Health
WHO	World Health Organization
SOP	Standard of Practice
NFMOH.....	Nigeria Federal Ministry of Health
STI.....	Sexually Transmitted Infection
CSP	Clinic Service Provider
CHEW	Community Health Extension Worker
PAC	Post Abortion Care
MVA.....	Manual Vacuum Aspiration

Background

Family Planning in Nigeria

Nigeria is the most populated country in Africa with a current estimated population of 123,300,000 people in mid-2000, more than four times the population of Kenya and three times the population of South Africa (2000 World Population Data Sheet, Population Reference Bureau). Nigeria's projected population in 2025 is 204,500,000. The country is also one of the world's poorest countries with an estimated per capita GNP in 1998 of \$300 US dollars (2000 World Population Data Sheet, Population Reference Bureau).

The total fertility rate (TFR) in the country stands at 6.0, well above the world TFR of 2.9, the less developed world TFR 3.2 and even the TFR of 5.8 of Saharan Africa.

According to survey data, knowledge of modern contraceptive methods among women has increased. However data from 1998 show an overall 19.3% CPR with only a 9.9% rate for non-condom methods (USAID Spot Survey 1998). Other sources report that only 7% of all married women were using modern contraceptive methods (DHS data, as reported by Population Bureau).

Nigeria has one of the highest maternal mortality rates (MMR) in the world: 800 deaths per 100,000 live births, compared to less than 10 deaths per 100,000 births in developed countries. Some estimates of MMR in Nigeria are as high as 1,000:100,000. Approximately 50-60% of the deaths are related to unsafe abortions or clandestinely performed abortions (*Addressing the Problem of UnSafe Abortion in Nigeria: The Strategic Plan for Post-abortion Care in Nigeria*, 1997). Abortion-related complications and deaths are particularly high among Nigerian adolescents. Reproductive tract infections common during the antenatal and postnatal periods, female genital cutting and obstetric fistula present other reproductive health challenges.

The HIV/AIDs epidemic is a serious public health problem in the country. Nigeria has the largest population of people living with HIV in West Africa—2.3 million (UNAIDS-1999). Some reports estimate that the figure is much higher: at least 5.5 million Nigerians infected with HIV. Almost 72% of infections occur in adults under 40 years old in both the urban and rural areas. Lack of access to and utilization of family planning services only further exacerbates the crisis.

Family planning services in Nigeria are provided by the public, NGO, and private sectors. At the primary health care level, local government unit (LGU) health centers in Nigeria's 36 states provide primary health care services including antenatal care, immunizations and growth monitoring, treatment of minor illnesses and injuries, and family planning. Various NGOs also provide family planning services including the Planned Parenthood Federation of Nigeria and others. Private, for-profit practitioners also provide services. In the three states visited by the PNA teams, there is a mix of public, NGO, and for-profit facilities as well as patent medicine stores and traditional healers. In Oyo, for example, there are an estimated 50 clinics in the public sector including 24 at the primary level, 25 at the secondary level and 1 at the tertiary level. It is estimated that 60% of FP/RH services are provided in urban areas and that 60% of overall sites are public sector clinics, 30% NGOs, and 10% in the for-profit sector.

Both the public and private sector in Nigeria reportedly suffered deterioration of their health facilities and services in recent years due to the country's political and economic instability. The

supply of drugs and contraceptives and the physical infrastructure of clinics, health centers and hospitals were severely impacted. There was a brain drain from the country in the 1990s. Today women, men, and children, particularly in rural areas, still have little or no access to health care and largely have their health needs attended to by patent medicine stores and traditional healers, if at all (HealthWise: An Integrated Health Approach to Strengthening the Private Sector, 1999).

National Context

Although a comprehensive assessment of family planning service delivery at the national-level was not one of the objectives we set out to achieve, we did gather valuable information at this level. In this section of the report we present brief summaries of key issues discussed in visits with other donors and federal Ministry of Health counterparts. We also discuss those performance gaps that were common to all three states visited, as well as recommended strategies for addressing them at the national level.

Community Development & Population Activities, Federal Ministry of Health, Abuja

A subgroup of the PNA team met with Dr. Amaeshi, Director of Community Development and Population Activities. The three major issues raised by Dr. Amaeshi in this meeting were contraceptive commodity security, lack of standards/protocols for family planning service delivery, and improving partnerships between the community, public sector, and private not-for-profit family planning service providers.

Contraceptive Commodity Security

Procurement of contraceptive commodity security has been a challenge ever since military rule and the end to donor public sector assistance. The current situation may be complicated by a decision to dissolve PAFA, made the week prior our visit. (PAFA is the unit through which contraceptive commodity procurement allocations are channeled.) Dr. Amaeshi said it was unclear what funding for contraceptive procurement would be reinstituted and who would manage it.

Standards of Practice and Family Planning Clinical Protocols

While counterparts in the FMOH, other donors, and USAID implementing partners consistently reported that the existing family planning guidelines were limited to a 1991 FMOH document and a two-page summary in a fairly recently developed "Expanded Life Saving Skills" curriculum, on our way out of the FMOH we were given *Clinical Protocols in RH for the Nurse-Midwife at the Primary Health Care Level*, Nov., 1999. Upon probing, we discovered that this document had been drafted with WHO financial and technical assistance. The content of this document was drafted primarily working from protocols from other countries. One person directly involved in this effort did not recollect having seen or used either the WHO and USAID documents on eligibility criteria and best FP service delivery practices.

Strengthening Public-Private Sector Partnerships and Community Involvement

Dr. Dr. Amaeshi expressed great interest in strengthening public and private sector partnerships. He indicated that there has been some successful partnering between NMOH and PPFN, but that these partnerships could be strengthened and implemented more systematically. He also believed

that there existed a potential role for community involvement in improving quality of services, making specific reference to a network of community-based organizations that was established under military rule. A national council formed to support this network does still exist as do coordinating bodies at state, LGA and primary health care unit-levels. He noted that these groups are currently underutilized, but that it may be a scheme worth reviving.

DIFD, Abuja

Liz Taylor, Health Advisor for International Health Development, indicated that after having worked with NGOs and focusing on social marketing approaches throughout military rule, DFID is now re-engaging with the MOH. DFID/Nigeria hopes to complete drafting a new strategy and workplan by May 2001. The current strategy is to work nationwide on HIV/AIDS only, continuing collaboration with SFH, the local social marketing organization. They will work with FMOH and State MOH in Benue, Jigawa, Ekiti, and a fourth state yet to be selected. Their focus will be on improving indigent peoples' access to health services in malaria, tuberculosis, reproductive health and immunization. Areas of intervention will be at the systems-level focusing on such financial, supply and logistics systems.

It is important to note that Liz Taylor expressed great appreciation for our visit and underscored the importance of strengthened USAID-DFID collaboration. She also specifically expressed interest in learning more about performance improvement methodologies.

UNFPA, Lagos

The team met with Dr. Fatusi, National Outreach Advisor. The Chief Technical Advisor was also present. UNFPA provides assistance to 12 states, typically working with approximately two-thirds of the local government units in any given state. The three components of their program are described as reproductive health, population and development strategies, and advocacy. Examples of concrete interventions they are currently implementing include piloting a new reproductive health curriculum, developing counseling approaches for adolescents, coordination of the National Reproductive Health Working Group, and exploratory research on perceptions of components of reproductive health (e.g. family planning, safemotherhood, etc). One of the initiatives they described as a success story was the development and support of a coalition of NGOs aimed at partnering well-established NGOs with newer NGOs, to strengthen and build their capacity. When asked about plans to support commodity procurement, they indicated that their funds have been fully programmed, but that in the future they may be able to provide limited support to the states with which they are working.

USAID's Focus

As mentioned above, voluntary family planning is one of USAID/Nigeria's strategic objectives, designed to increase the knowledge, acceptance and use of modern family planning in the country, particularly in USAID's 20 focus states as well as at the national level. A policy goal statement issued by the State Department's Africa Bureau calls for "expanding family programs in West Africa, particularly Nigeria, Mali, and Burkina Faso" (USAID Results Report/Resource Request, March 2000).

Prior to 1995, USAID/Nigeria provided family planning technical assistance and contraceptives to the public sector and NGOs. With de-certification during Nigeria's military dictatorship, support for the government sector was suspended, including contraceptive supplies, while NGO support continued.

In late January/early February 2001, USAID/Nigeria will re-examine its population strategy. Increased access to family planning/reproductive health services and modern contraceptives is expected to remain very strong. It is hoped that the performance needs assessment findings presented below may help to highlight performance problems in family planning service delivery and possible approaches to improve performance at the critical primary health care level.

Focusing on performance at the sector, organizational and provider levels is key at a time when many public and private health services organizations are striving to become more efficient, effective and sustainable and there is a demand for greater accountability of publicly funded organizations and more emphasis on results rather than inputs. The Government Performance and Results Act (GPRA) of 1993, PL 103-62 passed by the US Congress which affects all federally funded programs including USAID stresses performance. This legislation has had an impact on the way in which Federal agencies plan, budget, evaluate, and account for federal spending. Agencies are now held responsible for program results. The focus has shifted from inputs and processes to outputs, outcomes, and results.

PURPOSE AND OBJECTIVES

Purpose

The purpose of the Performance Needs Assessment (PNA) was to provide information to USAID in Washington and Nigeria on the current performance of family planning clinics and providers in Nigeria, as well as their needs. The information will be used in the a new USAID/Nigeria population strategy, the development of which will take place in early February 2001. To better apply emphasis in areas that will have the best chance of improving the performance and impact of family planning services, it was necessary to have current information about the state of performance.

Objectives

The Performance Needs Assessment conducted in December 2000 sought to answer the following questions with regard to clinic and provider performance:

- What is the **desired performance** of the clinics and providers, in the eyes of key stakeholders?
- What is the **actual performance** of the clinics and providers, compared to the desired levels of performance?
- Where gaps exists between desired and actual performance, what are the **root causes** of these gaps?
- For high-priority gaps (as defined by stakeholder groups) what are some areas of **intervention** that are likely to have high impact?

When examining desired and actual performance, the team focused on

- Primary-care clinics
- Primary-care providers
- The services offered
- The quality of those services
- The extent to which the needs of providers were being met in order to provide high-quality service.

Although family planning and reproductive health services are provided at the primary, secondary and tertiary levels of care in Nigeria, the performance needs assessment focused exclusively on family planning services at the primary health care level, specifically family planning services delivered by Non Governmental Organizations (NGOs) clinics and family planning services provided within local government unit health centers. Data were gathered in three states: Oyo, Bauchi and Enugu.

METHODOLOGY

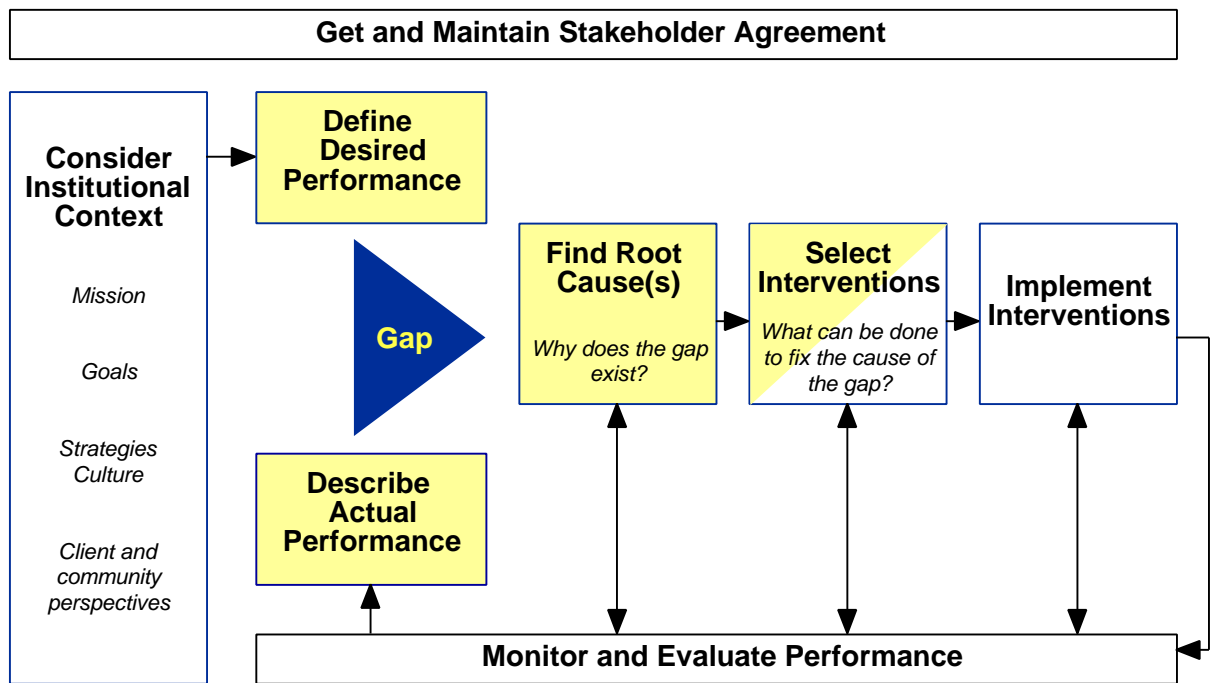
The Teams

The multidisciplinary team conducting the PNA was composed of representatives from USAID and its Cooperating Agencies including PRIME/Intrah and TRG, JHU, AVSC, and MSH. Nigerian colleagues from the Federal and State Ministries of Health were also indispensable members of the team. The team members have expertise and experience in clinical family planning and reproductive health service delivery, public health, performance improvement, and management. The teams collected data in three representative states of Nigeria: Ibadan in Oyo State (west), Enugu (east), and Bauchi (north).



The Performance Improvement Approach

In conducting the Nigeria's performance needs assessment, the team adopted the Performance Improvement approach endorsed by the USAID Performance Improvement Consultative Group (PICG), a group formed in January 2000 by USAID/Washington and comprised of staff from USAID staff and USAID Cooperating Agencies. Performance improvement (PI) is an on-going process that requires specific planning and design, methods and tools. PI is a systematic, step-by-step approach to improving organizational and job performance. The stages in PI include performance analysis or performance assessment, cause analysis, intervention selection and design, intervention implementation, and evaluation. The PICG performance improvement framework appears below.



Performance needs assessment or performance analysis, as it is also called, is the first step in the performance improvement process. In a Performance needs assessment it is key to first solicit and then maintain both the agreement of stakeholders to conduct the assessment as well as their active participation in the process. Information about the goals, mission and requirements of the organization and individual performers is initially gathered.

Once this has been accomplished, desired performance and actual performance at both the organizational and individual performer level are described. The outcome of performance analysis is the explanation of the gap or the difference between desired and actual performance.

Cause analysis is a careful examination of what caused the gap. As shown in the diagram above, these first two stages – Performance needs assessment and cause analysis – provide the necessary information for designing and subsequently implementing performance improvement interventions. Without first identifying and clarifying the problem or performance gap, it is unsound and certainly unsystematic to proceed to the other steps in the PI process (analyzing the cause of the performance gap, selecting or designing a solution, implementing it, etc.).

Team Preparation

Prior to carrying out the PNA in family planning service delivery sites in Oyo, Enugu, and Bauchi, the team held initial preparatory and key informant meetings in Washington D.C. The team planning meetings were instrumental in allowing the team to be maximally effective in such a short period in-country (2 weeks). The team planning meetings allowed the team members to immediately start working on arrival in Nigeria. Team goals, roles and responsibilities, and coordination points were emphasized.

Team Orientation in Nigeria

The team was briefed by USAID Nigeria in Lagos and reviewed earlier assessments (e.g., World Bank, Health Wise, etc). They were also briefed by UNFPA on their overall activities in country, specifically the UNFPA facilities study conducted in 1999 in the UNFPA Nigeria states.

Additionally, two separate discussions were held with USAID Implementing Partners (IPs) in Nigeria, one before going to the field and another meeting upon returning from the field with the performance assessment data. A meeting was also held in the Nigerian capital of Abuja with the Federal Health Ministry to discuss the planned Performance Needs Assessments. The state family planning Coordinator/Supervisor from each of the target states accompanied the teams throughout the performance assessment. IP staff in the USAID Regional Offices in each of the three field locations participated in the planning and implementation of the PNA field work, particularly the focus group discussions.

Data Gathering In the Field

The performance needs assessment was conducted in three states chosen by USAID/Nigeria: Bauchi, Oyo, and Enugu.

The PNA was conducted by a team of 3–4 people in each state with a combination of clinical, family planning and reproductive health, public health, management and performance improvement skills and experience. There was a member of the Nigerian federal Ministry of Health on every team. Team members are listed in Appendix B.

Upon arriving in each state, the first step in the PNA process was to describe Desired Performance and Actual Performance at the site and the provider levels of performance. The PNA team utilized stakeholder meetings and client/community input to describe Desired Performance. Describing Desired Performance involves establishing what the performance of the site or the family planning provider should be, according to institutional requirements, strategies, norms and standards, the needs of the population, and other criteria.

The team used stakeholders meetings, client/community input via focus group discussions, and on-site observation of family planning service delivery sites and providers to describe Actual Performance. Actual Performance is what the performance is at the present. The gap between Desired and Actual Performance may be positive, negative, or neutral.

More detail on describing desired and actual performance and analyzing the gap or difference between them is provided below. Instruments used during each phase of data gathering are presented in Appendix D.

Stakeholder Meetings

The PNA teams conducted day-long meetings with stakeholders from the NGO and the public sector in Bauchi, Oyo, and Enugu. The stakeholder meetings supplied data on

- **Desired Performance**
- **Actual Performance**

- Possible **Root Causes** of performance gaps

Stakeholder meetings included participation by clinic clients, providers (nurses, midwives, and physicians), administrators, representatives of community organizations, health managers and providers from various health care levels, and ministries of health staff. The Stakeholder meeting consisted of several structured exercises to allow the assembled experts, in small groups and in plenary, to arrive at the statements of desired and actual performance, and to then prioritize any performance gaps found. A sample agenda for a Stakeholder Meeting appears in Appendix D.

After discussing the Performance Improvement approach and specifically the first two steps of PI (PNA and cause analysis), an Environment Scan was conducted which elicited information from the participants on the local health situation in each area (e.g., health problems and risks, availability of health services, other health resources or lack thereof, etc). The participants worked in small groups to establish Desired Performance at the site and provider levels. The groups then met in a plenary session to arrive at consensus about Desired Performance. Following that, participants returned to small groups to discuss Actual Performance at both the overall site and provider levels of performance. Again the larger group met in a plenary session to arrive at consensus about Actual Performance. Gaps between Desired and Actual Performance were discussed and prioritized. The participants analyzed the causes for the difference or gap between Desired and Actual Performance, considering various performance factors or drivers. At the request of USAID/Nigeria, possible interventions to improve performance were discussed, although not in great depth. Results from this process are provided in the Findings section of the report.

It is important to note that the PNA team did not arrive at the meetings with pre-established standards for desired performance. The range and depth of the participants in the Stakeholders Meetings allowed them to develop the performance statements themselves.

Focus Group Discussions

The PNA teams conducted 1/2-day focus group discussions with clients and non-clients, both male and female. Non-clients are those who had never used the FP facility. The focus group discussions supplied data on

- Desired Performance
- Actual Performance

Focus group discussions were held in order to elicit community and client input on Desired and Actual performance. In Enugu, two focus group discussions (FGDs) were held; in Bauchi, four FGDs were held; and in Oyo state, four FGDs were held. Results and notes from the focus group discussions is found in Appendix E. The focus group discussion questions can be found in Appendix D. The focus group discussions were conducted in the local language by Facilitators and Note Takers from JHU/CCP.

Participants in the FGDs were asked their views on Desired Performance at family planning sites and among family planning providers. Their input helped further inform and orient the Desired Performance statements produced at the Stakeholder meetings. Focus group participants who had sought services from local family planning facilities were also asked about Actual performance and

the experiences that they had as clients at FP site. The focus group discussions with non-clients helped explain why some people were not utilizing modern family planning methods or the family planning services available locally.

On-Site Observations

The PNA teams conducted visits to primary level family planning clinics to observe conditions and provider performance. The on-site observations supplied data on

- **Actual Performance**
- Possible **Root Causes** of performance gaps

To corroborate Actual Performance described in the Stakeholders Meetings and by the clients in the Focus Group Discussions, the PNA teams made observational visits to a select number of LGU primary health centers where family planning services are offered and NGO family planning clinics at the primary health care level.

In Enugu, visits were made to 5 facilities, in Oyo State, 6 sites, and in Bauchi State, 6.

FINDINGS

Findings on Desired Performance and Actual Performance at the site level and at the provider level, as well as the root causes of performance gaps are reported below, first for the entire country, and then for each of the states in Nigeria that the teams visited.

Findings Common to All Sites

While there are many distinctions in each Nigerian state, and certainly between the three major regions of Nigeria, the three data gathering teams did find some commonalities in the data.

Common Performance Gaps—Clinics

The performance gaps at the clinic level common to clinics in all three field locations were:

- Deficits in overall management, management systems and processes:
 - Planning and goal setting
 - Financial sustainability and management
 - Performance management (supervision, performance planning and training)
 - Management information system
 - Quality assurance system
 - Logistics
 - Monitoring and Evaluation
 - Service delivery policies, standards and protocols for family planning and reproductive health
- Continued/greater community outreach, awareness and involvement in family planning/reproductive health needed to promote understanding of the importance of family planning and child spacing and to increase utilization of modern family planning methods.
- Deficits in availability and utilization of a range of family planning and reproductive health services and commodities.
- Deficits in Quality service delivery (need cleaner, more attractive, equipped facilities with an adequate number of trained providers).
- Lack of highly sustainable service delivery sites (organizational/site, programmatic and financial sustainability)

Common Performance Gaps—Providers

The performance gaps at the provider level common to all three field sites were:

- Deficiencies in interpersonal skills
- Deficiencies in counseling and screening procedures
- Accurate, up-to-date client service statistics and use of this data in planning. Also up-to-date, complete client records.
- Deficiencies in infection prevention practices

The top priority gaps identified in each of the three field locations are described below.

Bauchi State Findings

Below are the high priority performance gaps for Bauchi state. Stakeholders rated the relative importance of all gaps found. A complete list of desired performance, gaps, and root causes is found in Appendix F.

The Bauchi performance needs assessment was conducted primarily in Bauchi town. The majority of stakeholders consulted reside in the urban and peri-urban area. The one rural clinic visited differed from the urban sites in that it received literally no support, in terms of resources or supervision from the State Ministry of Health (MOH). On the other hand, it was the cleanest and best-organized site visited. The nurse midwife who ran the clinic was a creative problem solver and effectively overcome major barriers that her urban counterparts simply accepted. The team was also surprised to see that although a large portion of the Bauchi residents have pronatalist, anti-planning family beliefs, there is a significant core of innovators who are supportive of family planning use. While men generally do not attend clinics, the clients spoken to indicated that 30-40% of male spouses are not only supportive of use, but are willing to go to clinics with or for their wives. Factors that made services both more male and youth friendly were access to services at close of the business day and limiting visibility of the clinic from passersby. In Bauchi, little difference was observed when comparing quality of family planning services in NGO and public sector clinics.

Bauchi Priority Performance Gaps and Root Causes—Clinic

The four highest priority performance gaps at the clinic level in Bauchi are:

1. availability of a locally appropriate range of family planning services and commodities
2. record keeping systems
3. access for family planning users in rural areas and
4. the physical appearance of the site itself – cleanliness, posters, furniture

Each of these high-priority gaps is explained in more detail below.

1. Availability of A Locally-Appropriate Range of Family Planning Services and Commodities

Existing resources are insufficient to ensure services and a reliable supply of commodities. Stakeholders desired performance in this area was not to have a full range of methods and services, but rather to have a range that reflected local demand. Stockouts of many methods are frequent, if not constant. The general attitude among providers and site managers with regard to this issue is one of helplessness.

Root Cause: most appeared to be waiting for this issue to be solved at a higher institutional level and demonstrated little innovation or creativity in terms of mobilizing local resources or establishing cost-recovery schemes.

2. Record Keeping Systems

Systems for collecting, analyzing, reporting, and utilizing data for program management are deficient. To a large extent, record keeping is currently limited to client visits. Inventory of commodities and patient files vary in breadth and depth. Although monthly and/or quarterly reports of this limited data are produced, there is no evidence that the data are used. While the stakeholders consulted in the PNA process clearly thought this was a priority performance gap, they themselves, along with other managers interviewed, failed to demonstrate any use of data in site management or at any other level in their institutions.

Root Causes:

- lack of forms
- lack of management emphasis on record keeping
- lacked awareness of record keeping as important or as a job duty (job expectations)

3. Access in Rural Areas

Physical access to family planning sites for people in rural areas is limited due to scarcity of clinics and limited means of transportation. Stakeholders identified poor planning as the underlying cause of this performance gap.

Root Causes: it was observed that clinics are not distributed to reflect the distribution of rural population. Trained personnel are not deployed in a manner that maximizes coverage.

4. Physical Environment/Appearance

While cleanliness was the aspect of physical environment given greatest importance by clients, the PNA data indicate that site-level performance in this area is dismal. Other aspects of the physical environment of the site include posting attractive and informative posters and other IEC materials, as well as ensuring basic furnishing.

Root Cause: underlying causes are low standards set by site managers and unavailable resources.

Bauchi Priority Performance Gaps and Root Causes—Provider

The four highest priority performance gaps at the provider level, in descending order of importance are:

1. quality of interpersonal communication
2. proper application of steps in counseling
3. record keeping
4. infection prevention practices

1. Interpersonal Communication (IPC)

Definitions of desired performance in this area focused on providers 'being nice,' following norms of confidentiality, and treating clients in a respectful manner. Evidence of poor provider performance was seen consistently across all data sources. The major root cause identified for this gap was knowledge and skill in norms of quality client-centered communication. While this performance gap is most pronounced in provider interactions with poorer clients, data indicate that it exists across the board.

Root Causes:

- Providers lack the communication skills necessary to bridge both the 'technical' and socio-cultural divides that exist between providers and clients
- Providers lack vocabulary and expressions necessary to explain technical aspects of family planning in a way that clients can understand.
- At times, providers' unfamiliarity with clients' cultural norms results in unintentional offensiveness.

2. Steps in Counseling

The majority of family planning providers assessed in Bauchi have never received formal training in family planning counseling. Rather they have been trained on the job in an ad hoc fashion, often by people whose skills and knowledge are limited or outdated. Counseling practices, both observed and as described by the providers themselves, do not demonstrate state-of-the-art practices in family planning counseling.

Root Cause: Providers evidence a lack of skills and knowledge concerning current counseling methodology. Even when questioned in a simulation situation ("what would you say?") providers can not recall the appropriate steps of counseling.

3. Record Keeping

Data on provider performance in record keeping in Bauchi clinics varied slightly by site and data source. Stakeholders felt strongly that this issue should be on the final list of priority gaps to address, arguing that it an area of provider performance that can easily be addressed.

Root causes: interruption in the supply of record keeping forms and the complex nature of existing forms.

4. Infection Prevention

Providers did not follow the most basic steps of infection prevention during interaction with the client.

Root Cause:

- Lack of knowledge, skills, and tools were key contributors to poor provider performance in infection prevention. The data indicate that provider knowledge of such basics as proper dilution of bleach solutions for disinfection is minimal.
- The essential tools for effective infection prevention are either absent completely or malfunctioning (e.g. autoclaves and proper waste containers for sharps).

Enugu State Findings

The following performance gaps are the result of a summarization and prioritization exercise performed during the stakeholder meetings. The results from this exercise were then validated through focus groups with clients and non-clients, site visits, and interviews with community leaders.

Enugu Priority Performance Gaps and Root Causes—Clinic

The highest priority performance gaps at the clinic level in Enugu are:

1. Low client utilization of FP services
2. Deficient quality of services.
3. Inefficient management systems and processes.

1. Low client utilization of FP services.

Root Causes:

- Cultural and religious beliefs act as barriers to family planning utilization.
- Communities do not identify the services as their own, due to their lack of participation in the planning stages.
- Lack of continuity of services.

2. Deficient quality of services.

Root Causes:

- Lack of commitment/motivation of providers
- Lack of supervision/support/training systems
- Limited number of providers, and existing providers have multiples tasks

3. Inefficient management systems and processes.

Root Causes:

- Lack of adequate government budget allocation.
- Lack of staff (manager) development.

Enugu Priority Performance Gaps and Root Causes—Provider

The highest priority performance gaps at the provider level in Enugu are:

1. Deficient provider services in: counseling, infection prevention practices, and integration of FP and RH services.
2. Poor record keeping.

3. Deficient client and community education and outreach.

1. Deficient provider services in: counseling, infection prevention practices, and integration of FP and RH services

Counseling and information giving were identified as important neglected areas. Various issues were raised regarding this including the quality and content of the information provided to clients, the lack of privacy for clients, lack of client information (e.g., posters, etc.), provider appearance, and in some cases, provider attitudes toward clients.

Root Causes

- Provider personal bias related to modern family planning (religious and cultural).
- Lack of resources for infection prevention (e.g., water, electricity, sterilization equipment).
- Outdated skills and knowledge.

2. Poor record keeping

There is no working management information system. Consequently it is impossible to monitor and evaluate client characteristics and service utilization. Data are not used for planning purposes or site management.

Root Causes:

- No established and functioning management information system.
- No performance expectations from managers that providers should do this.

3. Deficient client and community education and outreach.

It is unclear who, if anyone at the clinics, is responsible for community outreach. CHEWs are presumably responsible for outreach, but spend much of their time seeing clients in the clinic.

Root Causes:

- Unclear job expectations of anyone to do outreach activities.
- Lack of motivation to do outreach.
- Lack of safety or security for staff to do outreach in the community.
- Lack of transport (or funding) to do outreach beyond walking distance.

Oyo State Findings

In Oyo State, family planning/reproductive health services are provided in both the public/government and the NGO/private sectors. There are an estimated 50 clinics in the public sector including 24 at the primary level, 25 at the secondary level, and 1 at the tertiary level. It is estimated that 60% of FP/RH services are provided in urban areas and that 60% of overall sites are public sector clinics, 30% NGOs and 10% in the private sector. Site visits were conducted in 4 Local Government Area clinics in urban, semi-urban, and rural settings, and in 2 NGO clinics (ARFH and PPFN).

Oyo Priority Performance Gaps and Root Causes—Clinic

The highest priority performance gaps at the clinic level in Oyo are:

1. Irregular supplies and commodities
2. Inadequate logistical support for effective supervision and monitoring.
3. Lack of management processes such as job descriptions, performance expectations, systems for feedback and self-evaluation and supervision/monitoring.

1. Supplies and commodities frequently unavailable to clients.

Supplies and commodities suffer frequent stock-outs. Clients frequently experience the non-availability of contraceptive methods at the primary service delivery sites.

Root causes:

- Political instability, government policies, and lack of support.
- Lack of commitment of corporate organizations who may be in the position to contribute.
- Inability to project, acquire and maintain adequate stocks of family planning commodities because of inadequate planning.
- Contraceptives were mainly donor supported in the past with no on-going donor sustainability of these resources.

2. Absent supportive supervision and monitoring.

Root causes:

- Lack of transportation
- No incentives
- Lack of training of supervisors on effective models of supervision

3. Lack of management processes such as job descriptions, performance expectations, systems for feedback and self-evaluation, and supervision/monitoring.

Root causes:

- Lack of resources
- No appropriate planning
- No training is available to upgrade the management skills

Oyo Priority Performance Gaps and Root Causes—Provider

The highest priority performance gaps at the provider level in Oyo are:

1. Providers are not performing according to standards
2. Inadequate FP/RH knowledge and skills of some primary providers, particularly at the public sector and at rural sites
3. Inadequate infection prevention practices
4. Missed opportunities for integration between FP and RH services at the primary level including HIV/AIDS, Adolescents' RH and Post Abortion Care

1. Providers are not performing according to standards

Root causes:

- FP Standards of Practices have not been revised, updated or disseminated since 1992 due to the political situation.
- Need a comprehensive plan to review, update, disseminate and ensure the application and adherence to SOPs.
- New WHO eligibility criteria have not been disseminated.

2. Providers provide Inadequate FP/RH knowledge during counseling sessions, particularly in the public sector, and at rural sites.

Root causes:

- Bureaucracy and frequent transfer of providers to sites/positions where the skills are not fully utilized.
- Absence of training or continued education
- Inadequate curricula
- Lack of financial resources.

3. Inadequate infection prevention practices

Root causes:

- Lack of correct knowledge and information
- No running water, lack of equipment and supplies at the primary health sites.
- No supervision

- Non dissemination of the standards of practices (SOPs)

4. Missed opportunities for integration between FP and RH services at the primary level including HIV/AIDS, Adolescents' RH and Post Abortion Care

Root causes:

- Programs are vertical.
- Lack of training on integrated service provision.
- Lack of integrated service standards or protocols and out-dated standards.

POSSIBLE PERFORMANCE IMPROVEMENT INTERVENTION AREAS

The focus of this report and the technical work conducted in Nigeria was Performance Needs Assessment (and root cause analysis). Designing or selecting interventions to improve performance is a separate step in the Performance Improvement process that must be thoughtfully and carefully done with stakeholders, based on findings from performance analysis and root cause analysis.

The team did, nonetheless, form some impressions of broad intervention areas for further investigation. The team had some discussion with the stakeholders in the three states visited on possible interventions to improve performance at both the overall site and provider levels in FP services at the primary health care level in LGA health centers and NGO clinics. Listed below are some of the PI interventions proposed. Both suggested national PI interventions as well as state specific PI interventions are provided.

National Level Intervention Areas

Below are suggested general areas of intervention proposed based on common themes from input from stakeholders at various levels and PNA team root cause analysis for priority performance gaps at the state level. It should be noted that a thorough root cause analysis was not conducted with regards to national level. Also, some of the common themes in performance gaps are not addressed below because the interventions may be more appropriate at the level of the state. The items below are listed in general order of priority based on frequency with which they were mentioned and importance they were given by stakeholders.

Contraceptive Commodity Security

- Strengthen donor coordination and advocacy for this crucial issue.
- Leverage support from other donors not currently working in RH. For example, although the World Bank is currently working with MOH counterparts to draft strategies/action plans for health sector reform, discussion with FMOH indicates that people involved in RH are not involved. Help put RH on the agenda.
- Provide or leverage support from another donor to establish local health-financing schemes.

Standards of Practice and Service Delivery Guidelines

- Bring state-of-the-art, evidence-based reference documents into the country and distribute to key partners. (e.g. WHO *Eligibility Criteria*, USAID/WHO *Recommendations for Best Practices... Vol. I & II* and other references endorsed by the MAQ Initiative)
- Review 1999 NFMOH/WHO service delivery guidelines to ensure they reflect up-to-date clinical practices, including effective interpersonal communication and counseling.
- Ensure that pre-service training curricula and certification exams reflect state-of-the-art practices in infection prevention, counseling, and other clinical skills.

Management Systems

- Advocate for Federal-level support for improved management systems at the state level. While much management and coordination for Primary-level providers (the focus of our study), will

happen at the local and state levels, Federal management will have a role in placing sustainable management systems.

Oyo State Intervention Areas

- Work with the FMOH, SMOH, NGOs and other Stakeholders to review/develop, update, disseminate, and ensure the application of the updated national FP/RH Standards and protocols including infection prevention practices. The updated FP Standards of Practice will integrate recent WHO eligibility criteria for Family Planning methods as well as selective RH services as post-abortion care, postpartum contraception, adolescents' reproductive health services and prevention/management of STIs, HIV and AIDS.
- Work with the Federal Ministry of Health, Ministry of Education, NGOs, and other relevant institutions to create linkages between pre-service, in-service training, and continued education programs. This will include the development of unified and standardized training curricula for Family Planning and Reproductive Health with a special emphasis on the use of Alternative Training Approaches such as Self-Directed Learning, On the Job Training and other more sustainable methods.
- Develop and ensure the function of the management systems that support the sustainability and institutionalization of FP/RH services, e.g., logistic, referral, training, supervision, and documentation systems. This will include utilizing the successful experiences of active NGOs to provide training and sustain the provision of commodities within the public sector.
- Work with NGOs active in the community to ensure the involvement of community in the identification of needs, planning, mobilization of resources, implementation and evaluation of FP/RH services provided at the primary level. This will include a consumer-driven quality approach to maximize the quality of provided services.
- Promote the dissemination and use of the Performance Improvement Approach as a way of maximizing investment in FP/RH Human Resources Development and other interventions, access and quality and ensuring focus on results.

Enugu State Intervention Areas

- More material, financial, and human resources for clinics and health centers at the primary health care level to support the delivery of quality FP/RH services to clients (e.g., personnel where needed, equipment, steady flow of contraceptive commodities, repaired facilities, training opportunities in areas cited above, supervision, etc.)
- Management and leadership development support and training at different levels in the public sector including planning, MIS, quality assurance human resource management (including but not limited to supervision), supplies and equipment logistics management, financial management and financial sustainability)

- Training for primary providers in counselling, infection prevention and integration of family planning and reproductive health.

Bauchi State Intervention Areas

- Put in place self-sustainable management systems. Often, good initiatives are sparked by the availability of donor dollars *and donor management*. Because efforts are not made to build the capacity of local management to sustain systems, when the donors leave, the system collapses. Government and NGO Management possess the capacity to learn and the motivation to sustain systems in their organizations. A part of each intervention should be to build the capacity of local management to manage systems that are left behind. While such “back office” areas of emphasis are perhaps often seen as less immediate in their impact (as compared to training or commodities purchase), they are critical to the sustainability of any other interventions.
- Encourage the formation of public/private partnerships. The public, for-profit sector is an important delivery mechanism for FP/RH services in Bauchi state. Previously, public (State) and for-profit sites have formed ad-hoc partnerships to share supplies and expertise, and to cross-refer. State regulations stopped this partnership. De-regulation of this casual commerce, and encouragement of partnerships will add to the total capacity of the whole system to serve FP.RH clients.

APPENDIX C FOCUS GROUP DISCUSSION NOTES

Oyo State

- Clients generally have a favorable impression of the FP clinic environment describing it as clean and neat with waiting rooms well ventilated and comfortable.
- The service providers are perceived to be competent, helpful and highly experienced. Because of this they recommend the clinics to friends and relatives
- Accessibility to the clinics was also judged adequate with most clients being able to reach them between 10 minutes to an hour. Clients know the clinic opening hours.
- Clients generally prefer “older” providers sometimes describing the younger ones as rude
- Although there is no sign posts, clients are aware of the availability of Family Planning services
- Lack of commodities and inadequate equipment is a problem.
- There are not enough IEC materials.
- The number of service providers in the clinic is not adequate.
- Strong opposition of husbands reduces Family Planning use.
- There continues to be persistent rumors about the negative effects of contraceptives.
- There is not enough “enlightenment” program especially for men.

Bauchi State

Clients perceptions:

- **Cleanliness:** waiting areas are generally clean and have adequate seating. Examining room cleanliness varies quite a bit from clinic to clinic. 'Environment is clean and nice.' Vs. 'In rural areas clinics are terrible in terms of hygiene.'
- **Client flow:** FP providers at times are taken away from FP service provision to handle 'more urgent cases.' 'Visitors' stop by to talk with providers, sometimes at length. Respondents said never know when visitors are on work or personal related business. Sometimes 'Nobody is attending to patients in govt. clinics and this attitude compels patients to patronize private clinics and chem shops.'
- **Privacy:** General satisfaction with privacy. "Really private because you take turns, one after the other."
- **Equipment:** Women particularly noted the lack of modern, functioning equipment in FP facilities.
- **Posters:** Women mentioned posters showing ideal family size vs. women with many children close in age. They encourage them to use FP so "...that you wouldn't want to be a victim of such, thus you will space your children. It encourages us to plan."
- **Provider attitude:** Respondents all indicated that providers were friendly. They listen to and help solve your problems. Women noted that they strongly prefer to be seen by women, not men. They feel it improper to be seen by a man. For most part they felt they could trust providers.
- **Provider Skill:** While some said it is hard to know if a provider is skilled or trained, they felt it was important issue. A few women gave examples of what they believe a trained person should do (e.g. examine before giving a method). Generally thought doctors were better trained than nurses, but again, would not want to see a man - and most doctors are men.
- **Recommend facility to friends interested in FP:** Yes would recommend. (One said if friend was unhappy with services, might recommend a private clinic because you could be seen by a doctor. Another mentioned the General Hospital.)

Non-clients perceptions:

- **How would you describe the clinic environment:** Majority said that they would advise others to not use FP and wouldn't bother describing anything. There were multiple references to the Koranic laws and norms that preclude 'planning' births. "I will tell her not to go because what will be will be. If God says she will give birth to 10 children there is no going back. She will give birth to the 10 children." One male and one female respondent did say that would support use of FP only if a woman's health is at risk. "I would advise that person not even attempt to go to FP clinic unless and until there is a serious danger." One woman described her own experience w/ FP several years back and later was unable to conceive when wanted a second child. For this reason she is not in favor of FP.
- **How would you describe your meeting with the family planning provider(s):** While some said providers are friendly, majority of non-clients agreed that providers have reputation for being 'arrogant', 'harsh' and mistreating clients, especially poor. Providers have been known to tell others in community that a woman is using FP. This is especially problematic if the woman is using with the consent of her husband. They believed that providers would be helpful if you

have a problem. One person mentioned that at times the provider does not speak the language of the client, communication is difficult and things are easily misunderstood.

- **Recommend facility to friends interested in FP:** Some responded emphatically – NO- based on religious believes and referred to methods that are acceptable according to the Koran (e.g. withdrawal & praying to God). One woman said maybe would recommend if they could help with infertility. Others mentioned that FP sites provide other types of health services that can be of benefit.

Enugu State

Client Perceptions – Clinic Conditions:

- **Timeliness of service delivery:** workers come late to open clinics and because I and most acceptors or clients also go to work we leave the clinic before it is opened. Long waiting times. There are delays and postponements.
- **Clinic hours:** clinic opens at 8 a.m. but I prefer it open also on Saturdays. I prefer that the clinic be allowed to remain open until 6 p.m. or run 2 shifts morning and evening. Rural health facilities do not have specific room/day for FP. They just announce that there will be FP service on such and such a day and on such days people are gathered under a tree shed.
- **Privacy:** no privacy. FP in the health center is just one room, not spacious and no privacy (Ogbete HC, Enugu). The officers take deliveries, see FP client, etc. in the same room and using the same facilities. Lack of privacy is a put-off.
- **Distance/proximity of clinic or health center to house or work:** distance is long. About 45 minutes from my house (Park Lane Hospital). Health facility is near my residence.
- **Physical Conditions of the clinic/health center:** environment is not encouraging, no good space and no privacy; one long corridor/bench for waiting for all clients/patients including sick and very sick people and their relations waiting to receive to receive other primary health services. Mixing with other patients discourages potential clients or even continuing users due to societal inhibitions. Examination rooms are not good enough, crowded. Stopped attending public health facility because of its poor condition. Rural clinics are worse than urban clinics. Many items are stored in the room (examining room) as if it is a store.
- **Hygiene:** hygiene is not good enough. No light or water sometimes.
- **Equipment:** FP clinics do not have blood pressure measuring instruments, instrument sterilization facilities and other facilities that are required.
- **Staff:** not adequately staffed. FP clinic personnel perceived as well trained, knowledgeable and understanding and ready to assist clients. All FGD participants agree that clinic staff keep their clients' secrets. Workers concentrate on health talks and referrals. The providers are friendly and show that if given the right facilities/instruments they will perform. Presence of student nurses a put-off. Their appearance and the appearance of the work place do not give them good personality/appearance to make clients trust them and look upon them for help. Providers understand client positions well, answer questions well and ask questions too. The provider gives me what I want without allowing people around to know what she gave me. They are reliable and keep code of ethics. (I liked) the way the provider convinced my husband to allow me to do FP (modern method).
- **Cost:** cost introduced in government clinics recently may discourage some people who may feel they would not be able to pay for FP services.

Client Perceptions – Desired Conditions:

- Spacious, properly ventilated and well furnished accommodations.
- Comfortable waiting room with some things such as comfortable seats, TV/ video, cassette player, and reading materials. These resources would help ease tension and boredom while clients wait. Video tapes on family planning should be played in the waiting room.
- The waiting room and the examining room should be situated such that patients and other visitors to the clinic do not mingle with clients. Clients need their privacy. Separate building for FP acceptors to receive services.
- The service providers should be adequate, well trained, and provided with all the necessary facilities required for their jobs. Providers should be polite, smiling, cheerful. Listen to complaints and respond accordingly. Good appearance and reception of clients.
- Service sites should be established in rural communities since people from there find it difficult to access those in towns. Or in the interim mobile FP services should be packaged to reach people in remote areas.
- Providers should not be young people. They should be mature and experienced mothers, whom clients can see as models. Prefer elderly women instead of young ladies/ student nurses. Elderly women have gone through childbirth and have more experience. Always use trained FP providers. Do not send untrained and inexperienced nurse to FP clinics when the trained provider goes on leave.
- Need more providers
- Clinics should have attached to them GYN. and Pharmacy units so that clients who have problems and those who need drugs are attended to immediately.
- Ready availability of sterilizers, examination couches, good BP apparatus, and other facilities.
- Need for MD in clinic.
- Posters depicting situations warranting FP and giving the necessary information to clients, handbills, videos (it would be nice to be able to borrow some of the tapes and books).
- Display of samples of contraceptive methods.
- Contraceptives are of the right quality.
- Want reinforcement of FP information with video clips.
- Separate tables for individual nurses to be able to talk with clients without any interference.
- Snack room.

Client Perceptions – reason for gap between actual and desired state:

- Lack of understanding of what people want.
- Government does not see family planning as a priority.
- Enough awareness has not been created on family planning.
- Family planning clinics lack the funds to provide appropriate accommodation, hire adequate/trained personnel and provide them with needed facilities.

Client Perceptions – What would do first if you were the providers/administrators?

- Upgrading and improving existing accommodation and facility (infrastructure).
- Hiring/training FP personnel.
- Creation of FP awareness.
- Funding.

- Free services and information.

Non-Client Perceptions – What have you heard about the clinic that a prospective client might not like?

- Dirty environment due to lack of personnel to sweep.
- No spacious waiting room/sitting room leading to others hearing what client is telling provider.
- Being asked to pay some money for service.
- All things are not available in health center. A number of things lacking.

Non-Client Perceptions – Desired Conditions:

- Laboratory.
- Gynecologist in clinics.
- FP services should be made free to increase acceptance.
- Mobile clinics to client areas to reduce defaults. More clinics in more locations.
- Trainings, workshops, and orientation for providers and clients respectively. Providers skills will increase and clients will become increasingly aware.
- Providers skilled and well trained, with good appearance and right attitude.
- Well paid, staff, good counseling skills, cheerful, kind, and friendly.

Non-Client Perceptions – Gaps Between Desired Conditions and Actual Conditions:

- Inadequate number of equipment/instruments.
- Shortage of staff.

Non-Client Perceptions – Reasons for Gaps:

- Lack of funds.
- Inadequate number of personnel.
- Inadequate accommodation for providers and office block for privacy.
- Inadequate number of referrals

Non-Client Perceptions – What Changes Should Be Made:

- Provide funds and make sure that funds are properly utilized.
- Provide equipment/accommodation.
- Manpower.

Non-Client Perceptions – Why are you not a user of FP:

- Just started family and people tell me that FP contraceptives destroy certain cells in the body.
- Religious beliefs (Catholic).
- I am a lab worker and I have seen users of FP methods presenting problems due to contraceptives.

- Newly married and religion supports natural family planning methods and (I/we) receive counseling on it.
- Accepts natural FP as Christian and as God's injunction not to commit murder. Contraceptives cause abortion of fertilized fetuses.
- When I get the number of children I want I will use FP methods.

APPENDIX D

DETAILED FINDINGS:

DESIRED PERFORMANCE

ACTUAL PERFORMANCE

GAPS AND ROOT CAUSES

For each of the three states visited, this Appendix lists detailed finding on

- Clinic desired Performance
- Clinic actual performance
- Clinic performance gaps and root causes
- Provider desired performance
- Provider actual performance
- Provider performance gaps and root causes

Findings in Oyo State

Clinic Desired Performance—Oyo

The following are statements of desired performance generated by stakeholders in Oyo State.

- **Family planning service delivery sites are available and accessible.**
Family planning sites exist in every local government unit throughout the state and in all densely populated areas and are accessible to most clients. Sites are hygienic, clean, attractive and conducive environments. The clinic has a sound structure and is free of physical conditions that may cause accidents or risks to clients, e.g. no rough floors, leaking roofs or cracked walls, permanent lighting good ventilation and potable water resource. Toilets are available and functioning. They are clean and have running water. The clinic has adequate space for different activities and storage. Privacy and confidentiality are guaranteed for all provided services
- **Facilities have the necessary drugs, family planning (FP) commodities and, consumables at all times.**
They have an adequate method mix and are equipped with the necessary equipment, instruments and materials needed to do the FP work including but not limited to IUD insertion kits, sterilizing units, weighing scales and sphygmomanometer. FP clinics have equipment checklists to ensure the functional status of all equipment.
- **Sites have an adequate number of providers who are well trained, competent and knowledgeable about the clients' expectations, needs, and FP services.**

Providers are who are involved in training and continuing education programs and opportunities. Clinic staff are client friendly and willing to offer good services. Providers offer quality FP services to all clients without discrimination and at affordable costs.

- **Sites have signs that inform the clients about the available services.**
[Yvonne: can we elevate this beyond “signs”? how about IEC materials and methods inside and outside the clinic walls?] Sites have adequate number of educational posters, visual aids and culturally acceptable IEC materials available for clients and conduct media campaigns to inform their clients about the services available and create awareness among the public.
- **Sites have all the necessary record forms and registers available at the clinic.**
Good records are kept of all the provided activities.
- **Waiting time is short.**
Sites have mechanisms in place to reduce the clients’ waiting time and utilize the waiting time in health education and group discussions about FP issues. Work schedules conform to needs of clients.
- **Site services are sustainable.**
Sites ensure sustainability of its services through cost sharing mechanisms.
- **RH and FP are integrated.**
Delivery sites integrate Reproductive Health (RH) with FP as much as possible in order to contribute in the battle against HIV/ AIDS by educating clients and providing youth-friendly services. Infection prevention practices are employed and safe services to the clients are ensured.
- **The sites conduct frequent outreach activities.**
The sites possess the means to perform outreach activities (e.g., human resources and transportation). Community participation and involvement in FP services is promoted. FP clinics have a mechanism to collect and consider clients’ views about the services.
- **FP sites provide referrals.**
FP sites provide referrals, as needed, to other health facilities.
- **Sites undergo government review.**
Local government units regularly review staffing needs, staff salaries and incentives at the sites.
- **Service utilization is high.**
Sites achieve high client utilization of FP services.

Clinic Actual Performance—Oyo

- **There is a limited number of staff in the clinics.**
There is generally one nurse midwife (CSP) assisted by one or 2 CHEWS. In a rural clinic FP services are being handled by a matron. However client load was very limited in the public sector clinics.

- **FP and RH services are not well integrated.**
In public sector sites, services other than family planning include ante- natal, well baby weighing, immunization and treatment of minor ailments and they appear to be vertically with insufficient integration different providers and client forms.
- **There is no evidence of community outreach.**
Providers claim to conduct outreach programs in the community but could not cite specifics about what and how outreach activities are carried out.
- **Service availability is spotty.**
Services are supposed to be available from 8 a.m.-4 p.m. but the schedule seems to be very loose in the public sector. Services are available from Monday to Friday. In one LGA rural clinic the team was told services were available 24hrs.
- **Service utilization is low.**
In the clinics visited the attendance was very low and many reasons were given including that clients (market women) prefer to come after they have set up their stalls market, the month of Ramadan in Muslim communities etc.) Services are available from Monday to Friday. In one LGA rural clinic the team was told services were available 24hrs.
- **Clinic Mngement is absent.**
In public sector clinics, management processes seem to be totally absent. There was no evidence of any planning, goal setting, monitoring and evaluation of site activities.
- **Record keeping is insufficient.**
In most cases there was an absence of client forms. There was obvious effort to keep records, and monthly Registers.

Clinic Performance Gaps—Oyo

- **Irregular supplies of commodities and the non-availability of contraceptive methods at the primary service delivery sites (Note: NGO and public??)** (Root causes of performance gap: political instability, government policies and lack of support, lack of commitment of corporate organizations, inability to project, acquire and maintain adequate stocks of FP due to inadequate planning, contraceptives are mainly donor supported and there is no sustainability with donor support, economic situation, lack of funds allocated for contraceptives, and inadequate logistical system).
- **Inadequate logistical support for effective supervision and monitoring** (Root causes of performance gaps: lack of resources, lack of transportation, lack of incentives and lack of training of supervisors on effective models of supervision).
- **Lack of management processes such as job descriptions, performance expectations, systems for feedback and self-evaluation and supervision/monitoring** (Root causes of performance gap: resources, planning, training).

- **Inadequate method-mix in clinics and insufficient number of sites offering FP methods in rural areas** (Root causes of performance gap: instability of providing contraceptive methods, few men are in the profession which results in difficulty to reach to rural areas, lack of financial resources and materials, lack of motivation of providers, lack of long term planning and the number of sites for FP service delivery does not meet the needs of clients).
- **Unhygienic conditions, poor status, weak infrastructures and inadequate material support in terms of equipment, IEC/BCC materials and drugs** (Root causes of performance gap: financial causes, health sector is not a sector that generate a lot of money, government cannot do it alone and lack of maintenance of equipment).
- **Inadequate/ insufficient record keeping “MIS”** (Root causes of performance gap: lack of technical knowledge, ignorance and lack of financial resources).
- **Inadequate staffing of service delivery sites** (Root causes of performance gap: lack of manpower planning, lack of resources and uncoordinated assignments and placement of human resources).

Provider Desired Performance—Oyo

- **Providers demonstrate positive attitude and other personal characteristics and attitudes** (e.g., friendly and non-judgmental) and provide and maintain uninterrupted FP services.
- **Demonstrate mastery of updated FP/RH knowledge and skills in providing services.**
- **Promptly counsel clients on all FP services while demonstrating strong interpersonal and supporting the client choice of a contraceptive methods.**
- **Conduct an adequate clinical assessment, correctly perform breast examination and provide quality FP/RH services to clients using problem solving approaches.**
- **Safely and effectively provide FP methods available at the primary health delivery sites (all methods except surgical contraception and Norplant that should be provided at higher levels of service provision) and explain to clients the effectiveness, side effects, warning signs, advantages, disadvantages and follow up schedule.**
- **Counsel clients on the prevention and management of STIs, HIV and AIDS and refer high-risk clients for diagnosis and management.** Appropriately manage cases of STIs applying syndromic management algorithms and strongly promote condoms as dual protection method for protection against pregnancy and sexually transmitted diseases.
- **Recognize and manage complications of abortion appropriately.** Offer post-abortion FP counseling to all post-abortion clients and demonstrate skills in using the manual vacuum aspiration (MVA) to treat PAC complications.
- **Provide youth-friendly reproductive health services which are not be biased against adolescents’ reproductive health.**

- **Regularly conduct health education sessions inside the clinic and in the community and provide brochures and IEC materials on FP methods.** Effectively and regularly conduct outreach activities.
- **Apply a systematic approach to ensure regular follow up, adequate stock of FP commodities, good record, supervision, proper arrangement of space and equipment and manage appropriate referrals.**
- **Provide safe services by maintaining a high level of hygienic practice,** applying proper infection prevention practices/techniques of decontamination, disinfecting and sterilization of instruments and equipment.
- **Involve communities and particularly men in FP services,** show responsiveness to feedback and mobilize support for FP services.

Provider Actual Performance—Oyo

- Generally, the client load at the NGO clinics was higher than at the public ones. (Receive an average of about 20 clients/day at NGOs and a range from 0–3 per day in the public clinics.) During a visit to one urban public sector clinic, the only client that came was turned away because of a stock-out of IUDs. The client (new user who requested the method) was asked to come back in the afternoon.
- In general, the FP knowledge of the primary providers ranged from acceptable to excellent. However, with almost all providers there was evidence of some lack of sufficient provider skills and knowledge in the use of contraceptive methods. For example providers generally do not insert IUDs except during menstruation and do not provide other temporary back-up methods when they send the clients away. Furthermore, the FP knowledge of some public sector providers was found to be wrong, outdated or incomplete. During a simulated counseling session; a service provider at a rural health clinic mentioned that “the IUD prevents pregnancy by the horizontal arms blocking the passage of ova from the fallopian tubes to the uterus and prevents the passage of sperm by the blockage of the cervix by the IUD’s vertical arm”
- During the actual (at NGO clinic) and simulated (at public sector clinic) sessions, providers demonstrated good counseling skills with good background knowledge and information on FP methods. However, many did not spontaneously mention the side effects, warning signs and the disadvantages, although when reminded they mentioned them correctly. While there was a variety of IEC materials including counseling flip charts and method brochures displayed and distributed at the NGO clinics, public clinics in general did not have enough FP posters (the ones available are outdated) and did not have any brochures or pamphlets to give to clients. Not enough information materials were found on HIV/AIDS in the public sector clinics. Providers had not attempted to request IEC or information materials from the State Ministry Of Health (SMOH). The updated FP “Informed Choice” poster was only available at ARFH’s clinic.
- The contraceptive mix available at clinics visited was fairly adequate. The mix included: combined oral pills, injectables (Depo-Provera and Noresterate), IUDs and barrier methods (condoms and diaphragm). In two NGO clinic (PPFN and ARFH), female condoms were also

available. However, frequent shortages of contraceptive methods are not uncommon, particularly in the public sector, and many clients are turned away because of the non-availability of the FP methods.

- Condom promotion as a dual protection method is very weak. Some of the providers themselves are biased against promoting condoms especially with men. According to providers, clients accept all FP methods except condoms. Condoms are not accepted because they reduce pleasure and they are an indication that one is unfaithful or carrying a sexually transmitted disease.
- All providers demonstrated reasonable to excellent skills in IUD insertion and they correctly applied the non-touch technique for loading the IUD and the withdrawal technique during the insertion process.
- All providers were knowledgeable about conducting breast examination and taught their clients (during actual and simulation session) how to conduct self-breast examination.
- Most providers demonstrated acceptable knowledge and skills in history taking, general examination and pelvic examination. Furthermore they were able to successfully explain the correlation between the findings of the examination and the methods chosen or prescribed.
- There is obvious lack of integration of other RH services with FP, particularly in the public sector. Providers would do a better job in integrating STIs treatment, HIV/AIDS prevention counseling, and adolescents' RH services, if appropriately trained. The ARFH clinic is a very successful model of integration of adolescents' friendly reproductive health services, HIV/AIDS education, and STI management. However at that same site, although the MVA equipment is available, PAC services are not adequately provided. Many cases are referred to physicians at higher service delivery level. This was an indication that more could be done at both the policy and service delivery levels to make PAC services more available to clients.
- A few of the providers need an update in infection prevention knowledge and skills. "For example, one provider did not know about the use of chlorine solution for decontamination and others did not prepare the right potent solution. In some clinics, the instruments were removed from the decontamination solution directly to the boiler. Some used the tenaculum in cleaning the cervix, savlon is used as an antiseptic in all clinics and sterilized instruments are immersed in used savlon before use "for lubrication." In a few clinics it was noted that instruments were not cleaned with soap, water and a brush. Also in most clinics, there seems to be lack of correct knowledge and/or practice on how to dispose of contaminated materials or sharps. Gloves, antiseptics and decontamination solutions are not provided by the SMOH. Clinics buy these materials from revenues from their cost recovery contraceptive funds.
- Most of the nurses observed or contacted received the 6 week in-service Clinical Service Provider (CSP) FP training provided by the School of Family Health as part of their formal preparation. In general no further education/training opportunities to update the knowledge and skills of most providers in the public and private sectors. Some of the providers had been in the practice for more than 15 years and did not receive any further training or continued education.

- The FP Standards of Practice (1992) was found in one clinic only. Some providers did not even hear or know about it. All providers depend on their pre-service education and the information provided during the 6 weeks FP training as standards for their practice.
- There is no mechanism in place to evaluate the performance or provide feedback to all the providers. Furthermore, none of the visited sites had a self-evaluation tool/ checklist that providers can use to evaluate their own performance. Supervision is not adequately implemented to identify performance gaps and provide assistance to improve the performance.
- The infrastructure, general maintenance, cleanliness and equipment were found to be deteriorating in most of the public clinics, particularly in the rural one, with no running water and frequent cut off of electricity. No ovens or autoclaves in all public sites.
- Most public FP clinics do not have an adequate space to conduct quality FP counseling and services and ensure the privacy and confidentiality of each individual client.
- All clinics maintain good records for FP clients. Upon reviewing the trend, in particular new FP clients, the number of new acceptors in many public clinics is decreasing over time. This decline was attributed to the non-availability of FP methods.
- One of the factors that affect the provision of quality services at the public sector is the shortage of the number of staff providing services in the FP clinic. In one visited public clinic, one provider was found to be responsible for three services in the same time (FP clinic, maternity center and dispensary).
- In all public clinics there is a weak community participation and lack of men involvement in FP/RH services. Providers at the public sector mentioned that women prefer the injectable because they do not want their husbands to know about using FP. On the other hand, at ARFH, the clinic has involved the community into the RH/FP activities of the clinic and in particular in the social and sport activities of the adolescents. Also, at the PPFN clinic, the provider mentioned that lately she has noticed a new behavioral trend where many women presented in the clinic and mentioned that their husbands have asked them to go and seek FP services.
- In general, the outreach activities are not practiced due to the lack in the number of staff, lack of transportation and lack of motivation to go to the community. Absent outreach activities is the main reason behind the lack of involvement of the community in FP services and decline in numbers of new acceptors.

Provider Performance Gaps—Oyo

- **Absent or outdated FP/RH service policies, standards, protocols, norms and guidelines** (Root causes of performance gap: FP Standards of Practices “SOPs” have not been revised, updated or disseminated since 1992 due to the political situation, need a comprehensive plan to review, update, disseminate, ensure the application and adherence to SOPs + New WHO eligibility criteria have not been included).
- **Inadequate FP/RH knowledge and skills of some primary providers, particularly at the public sector and at rural sites.** (Root causes of performance gap: to weak capacity building

efforts, donor dependence, bureaucracy and frequent transfer of providers to sites/positions where the skills are not fully utilized. absence of training or continued education, inadequate curricula, lack of financial resources and lack of coordination of training activities).

- **Inadequate infection prevention practices** (Root causes of performance gap: lack of correct knowledge and information, lack of running water, lack of equipment and supplies, no supervision and no disseminated standards of practice.)
- **Weak linkages between pre-service, in-service training and continuing education** (root causes of performance gap: the different systems and the lack of standardized and updated curricula, e.g., Schools of nursing and in-service training are under the Ministry of Health system while the schools of medicine are under the Ministry of Education system. Existing Standards of Practice are outdated and no longer available in schools and service delivery sites, large number of FP/RH institutions and absence of nation or statewide systemic approaches).
- **Missed opportunities of integration between FP and RH services at the primary level including HIV/AIDS, Adolescents' RH and Post Abortion Care** (Root causes of performance gap: duplication of vertical programs by donors, providers are not trained to provide services in an integrated way, no integrated service standards or protocols, current standards need to be updated, it is not easy to tell your donor what you want, the agenda is donor-driven, many donors like to work in the prevention of HIV/AIDS but not in the treatment, the vertical nature of many donor and government programs).
- **Inadequate provision of FP services** (Root causes of performance gap: lack of equipment and commodities, e.g., Norplant should be provided by nurse midwives but very few nurse midwives and even physicians received training in Norplant, and those who know it do not have the equipment. Providers are not motivated to provide better quality services).
- **Non-committed providers at FP clinics** (Root causes of performance gap: not motivated, are not clear about their job expectations, there is no organizational structure, culture or support, and absent supervision).
- **Poor interpersonal relationships and client provider interactions in the FP clinics** (Root causes of performance gap: staff not motivated, not trained and no supervision).
- **Inadequate adolescents' RH services** (Root causes of performance gap: hostile cultural norms, providers' biases and judgmental attitudes as regards to adolescents' RH service utilization, providers believe that they are protecting adolescents, religious factors and morals, traditional practices and beliefs, societal influence as regards to adolescents, attitudes to sex "gender", male negative attitudes to FP).
- **Absent outreach activities at the primary level** (Root causes of performance gap: staff not motivated, no supervision and no transportation).
- **Inadequate public awareness and client information on FP methods** (Root causes of performance gap: ignorance, lack of provision of brochures and IEC materials that adequately describe the available FP methods, and lack of knowledge on the location of the FP clinics).

- **Lack of community participation, involvement and ownership of FP/RH programs.** (Root causes of performance gap: lack of community awareness and education about their rights to quality services, attitudes of community members who expect to take not to give, the health sector is sometimes not the best sector to reach to the community, e.g. ,agricultural and women groups are doing better job working with communities, need more integration between the health sector and other sectors to better approach communities, communities prefer to deal with Safe Motherhood or Child Survival programs than Family Planning because they see direct benefits, the university system is not developed to go to communities and using very traditional approaches for training like classroom activities).
- **Inadequate male involvement in RH** (Root causes of performance gap: efforts to involve male clients are minimal and male attitudes against FP).
- **Inappropriate attention to capacity building in current programs** (Root causes of performance gap: insufficient training of service providers, insufficient programs and minimal opportunities).

Bauchi State

Clinic Desired Performance—Bauchi

- **Clinics conduct outreach activities.**
Clinics conduct advocacy and community mobilization, and awareness campaigns for FP and RH
- **Clinics are accessible to clients.**
The clinics should be centrally located and within traveling distance of local clientele, in accordance with transportation standards of that community. A sign board should be in place so people know where the clinic is. The clinic should be open when most need to use it (e.g., afternoon).
- **The clinic has adequate physical plant.**
The clinic Adequate in terms of space, enough rooms, lighting, water, etc. There should be good light and ventilation, water, and electricity, and there should be privacy for counseling.
- **The clinic has adequate equipment to meet clients' needs.**
The equipment is relevant to the services needed, and it is up to date and in good repair. E.g., comfortable chairs, tables for clients, providers.
- **The clinic has the commodities needed by clients.**
Commodities are in good supply, there is a good supply system and good storage facility. The commodities should be affordable to the general clients in the community.
- **The clinic has the right staff on hand to meet client needs.**
Personnel are on hand when needed – both skilled and semi-skilled. Staff should be well-trained and capable for the job they are doing.
- **The clinic keeps good records.**
The clinic and its staff conduct good record keeping: daily data collection, graphs, and reports, including referrals made to other sites, for follow up.
- **Clinic managers evaluate the clinic.**
Program evaluation – baseline, mid-term, and final evaluations
- **The clinic has enough financing to sustain itself.**
Managers should see to financing: source funds from agencies and philanthropists by selling ideas to them which will be developed into a proposal Programs are in place to sustaining the programs of the clinic:
 - Sales of commodities – cost recovery
 - Donation from individuals
 - Donations from members
 - Voluntary services from other people, e.g., specialists
- **All clinic staff observe clients' rights**
- **The clinic offers a wide range of services**
The FP/RH services offered at the clinic should meet the vast majority of needs of the women/couples in that community. There should be commodities to support each service.
- **Clinic management solicits feedback**
In order to make sure services are adequate, managers should regularly solicit feedback from the clients and providers.
- **Services should be of high-quality.**
All services, whether counseling, treatment, injections, or any, should be of highest quality. The client is expected to go home with her drugs, card, next appointment date and feeling satisfied.
- **Services are convenient**

- In terms of convenience, services should meet expectations from clients, e.g., minimal times spent waiting, few interruptions.
- **Clinic employs infection prevention procedures.**
Infection prevention procedures (general cleanliness of the environment/equipment handling) are in place.

Clinic Performance Gaps—Bauchi

Five highest priority gaps in descending order:

1. Available range of contraceptive methods and services appropriate to service delivery site and community preferences.
2. Clinic register maintenance
3. Interpersonal relations/communication w/ specific focus on treating clients with respect and dignity
4. Infection prevention
5. Accessibility for rural populations in terms of distance to travel and lack of reliable transportation

Other themes for which performance gap was identified:

- Affordability – relative to locality, problem greatest in rural area. Additional cost of travel is contributor.
- Record keeping: vital stats; med. history; referrals. NB: financial and commodity record keeping was also mentioned but no consensus on existence of performance gap. The providers felt no gap existed and program managers, policy level, etc. believed the gap was significant.
- Privacy of provider (e.g. room for counseling, clinic obvious location and only offering FP)
- Confidentiality
- Continuity of services due to stockouts, inability of clients to pay, relocation of trained FP staff
- Informed choice – the choice component of this was extremely limited again due to stockouts
- Provider skill in contraceptive technology – more need to be trained

Provider Desired Performance—Bauchi

- **Providers are sensitive to cultural norms**
For their area, providers should know local religious customs that impact on F{ /RH services. Providers should speak the local language.
- **Provider have up-to-date knowledge of FP/RH.**
Providers know the latest techniques and information on side effects. They practice the latest counseling techniques. They know and use proper technique for providing the service. Know and use correct instruments. Know use of appropriate infection control techniques.
- **Providers have good interpersonal skills**
 - Offer a warm greeting
 - Patient
 - Tolerant
 - A good listener

- Non-judgmental
- Able to express self
- Humble
- Observe client dignity
- **Providers refer when appropriate**
The provider should be able to link and collaborate with NGO's, community, and other private sectors.
- **Providers offer quality service**
 - Offer wide range of service
 - Safe service
 - Infection prevention procedures are practiced
 - Meeting the clients' needs
 - Are correct in clinical procedures and knowledge
 - Providers tell about and offer a good choice of methods
- **Providers observe clients' rights**
 - Privacy/confidentiality
 - Time management – don't keep clients waiting too long
 - Continuity of care
 - Comfort while receiving service (freedom from unnecessary pain/discomfort).
- **Providers seek training**
Providers seek out training (refresher courses, continuously updated training) to meet demand of the job and interest. Providers utilize the outcome of training.
- **Providers are experienced.**
Providers should be in continuous practice
- **Providers maintain adequate records**
Providers track information about individual clients, to notice trends or problems that might crop up (e.g., increase in blood pressure over a few visits).
- **Providers ensure cleanliness of clinics**

Provider Performance Gaps—Bauchi

The four highest-priority gaps, in descending order of importance are:

1. Interpersonal skills
2. Steps of counseling
3. Record Keeping
4. Infection prevention

Other performance gaps are:

- Clients' rights
- Referral centers
- Display skills in IUD insertion, contact tracing
- Being friendly/pleasant
- Being accommodating, not aggressive
- Committed, diligent, dedicated
- Is a good role model

- Is focused on the client (not easily distracted)
- Is patient with clients
- Is punctual for work
- Shows initiative

Findings in Enugu State

Clinic Desired Performance—Enugu

- Increased numbers of clients utilize family planning services at the clinic or health center.
- An increased number of community residents in the area use reliable, modern contraceptive methods.
- Clinic services and family planning methods are available and accessible to more community residents.
- Family planning services and products are affordable for more community residents.
- NGO and LGA sites have financial stability and sustainability, generating more of their own revenue and receiving more appropriate budget allocations to deliver quality services.
- High quality family planning and reproductive health services are provided to clients, in a timely, confidential manner in clean, friendly facilities, with necessary equipment, commodities and other supplies available at all times.
- Primary providers competently deliver family planning services to clients.
- Clients are satisfied the services provided at the clinics and health centers.
- Staff at the clinic or health center have a high level of job satisfaction.
- Management systems and processes are efficient.
- Clients and communities are more aware the importance of FP/RH services and products and their availability.

Clinic Actual Performance—Enugu

- **There were few family planning clients at the sites visited and general under-utilization of family planning services:** The sites visited, both the local government unit health centers and the NGO site (PPFN), are under-utilized for family planning services, especially the LGA health centers, according to observations at sites in December and a review of FP clinic utilization records for the year 2000. More clients appear to attend LGA health centers for infant and child growth monitoring, immunizations, antenatal care and treatment of minor illnesses and injuries, than they attend for family planning services. There are many missed opportunities for integrated services.

There is a large Catholic population in Enugu. Participants in Stakeholders' Meetings and focus group discussions as well as staff at the health centers reported that religious beliefs influence utilization of modern family planning both among community residents and in some cases, staff who are Catholics or do not believe in family planning.

- **Few community residents apparently use modern family planning methods procured from the site or other outlets:** It was not possible to investigate the number of community residents utilizing modern methods because no community-wide surveys were conducted as part of this Performance Needs Assessment. Nonetheless, DHS and other data suggest that the use of modern methods is still very low in Nigeria. Also judging by the number of people attending the five clinics and health centers visited in Enugu, few are procuring modern family planning methods from public and NGO clinic outlets.
- **Inadequate accessibility of family planning services to clients and potential clients**

- At the sites visited, clinic hours, waiting time for clients at the facilities, staff work overload and lack of regular availability of contraceptive commodities at clinics and health centers are a problem.
- **Services and products may not be affordable for all community residents interested in procuring them.** LGA health centers and NGO clinics charge for services and products. There may be a financial barrier to access to services and products for some community residents, according to FGD participants, stakeholders and providers. A female community leader who lives within walking distance of one of the LGA health center visited and works as a volunteer providing education about modern family planning to households in her community, reported that many people never go the health center, choosing instead to go the herbalist. Money is a barrier to care for them.
- **LGA health centers do not have adequate budgets to refurbish sites and purchase and maintain necessary family planning equipment.** The sites visited were in poor physical condition, with the exception of the NGO clinic. There was no running water or electricity at most sites. Tables and lamps for examining for FP patients were broken or in poor repair. The LGA sites have “revolving funds” whereby they were able to keep a percentage of the money from sales. The rest of the money recovered is sent to the state FP coordinator to help cover supervision costs and other expenses. However because the volume of clients receiving family planning services and buying methods is low and the sites are only able to keep a small percentage of revenue generated from sales, they are extremely limited in their capacity to repairing equipment or procure new equipment with these funds or invest them in any other way in the site.
- Quality of care to clients is negatively impacted by facilities in poor physical condition (with exception of the NGO clinic), lack of sufficient privacy for FP clients, lack of functioning sterilizing equipment, lack of functioning lamps, exam tables and other equipment, commodity stock-outs, overworked staff in some of the LGA sites and other factors, despite attempts by family planning providers (in LGA health centers, the care is provided by public health nurses and Community Health Education Workers (CHEWs); in the NGO clinic visited the care was provided by a nurse). Commodities were available in all of the sites visited but there were stock-outs of some commodities and condoms in abundance that were about to expire (December 2000). Infection prevention practices and counseling to FP clients were deficient. Family planning guidelines and standards were found at only one site.
- Providers were observed in three of the five sites providing family planning services to clients. In the other two sites (LHU sites) there were no family planning clients at the time of the site visit, however the site was thoroughly inspected as in the case of the other sites and the PNA team member asked the provider questions about provision of care. The nurse providers have a good basic family planning knowledge and skills but need greater competency in counseling, infection prevention and integration of reproductive health with family planning. Provider competency is discussed further in provider performance below.
- Clients who participated in the Focus Group Discussions and had utilized local family planning services reported satisfaction with the services but complained about hours in some clinics, waiting times, occasional stock-outs and especially lack of privacy. They also felt that the

facilities should be in a better state of repair and the staff more client-oriented and friendly. FGD participants remarked that the people waiting to be seen in some sites can overhear conversations between providers and clients. Also FP clients must sit in general waiting areas which makes them feel uncomfortable as it draws attention to the fact that they are seeking FP services..

- Staff job satisfaction is compromised by poor working conditions in many sites and frustrations stemming from attending to many clients and client needs (in the LHUs), occasional lack of equipment and supplies, stock-outs and lack of on-going professional staff development.
- Management systems and processes were not observed to be efficient. In the government clinics visited there were no annual or monthly plans of action or performance objectives, either for the site or individual performers. No site visited had a quality improvement system. There were problems with the drugs and supplies logistics system as demonstrated by commodity stock-outs and problems procuring equipment and other supplies. Job descriptions were available only in the NGO clinic and were very generic. The State Ministry of Health Family Planning Coordinator supervises Family planning in LGA health centers. Unfortunately, she is unable to practice facilitative or problem-solving supervision due to lack of resources to solve basic infrastructure and equipment problems. Although she herself has a good basic knowledge in FP, she, like the local staff, needs additional training in the areas mentioned above. There is no regular staff development or performance planning and appraisal. The Management Information System (MIS) in the LGA health centers functions poorly. The data forms utilized were photocopies of forms previously distributed by the FMOH. They were not always kept current and data is not used for planning and decision making. LGA centers and the NGO clinic had no control over their budget and limited capacity in revenue generation. The cost recovery system did not support the purchase or repair of needed equipment, as mentioned above.
- **Client and community awareness of FP services and products:** participants at the stakeholder meetings, staff at the sites and participants in the FGDs felt that awareness of family planning services and methods had increased but that more education and outreach are needed, not only to community residents but also to local government officials, religious leaders, other community representatives, etc.

Clinic Performance Gaps—Enugu

By comparing desired performance and actual performance above, it is clear that there are performance gaps in each of the 11 areas of site level desired performance. These gaps and the root causes (noted in *italics*) underlying these gaps are listed below. Root cause analysis conducted in the Stakeholder Meetings was complemented by interviews with staff at the facilities visited.

- Under-utilization of family planning services/too few FP clients. (Root causes of performance gap: lack of equipment, regular stock of commodities and proper infrastructure; religious beliefs antagonistic to modern family planning; FP is not as prioritized as other services at LGA sites; insufficient community education and outreach; client dissatisfaction with other aspects of service delivery such as lack of privacy, wait times, traveling distance to services, etc.).

- Low numbers of community residents using modern methods. (Root causes of performance gap: many of the same root causes as above.)
- Services and methods are not always available and accessible. (Root causes of performance problem: stock-outs due to problems with logistics system planning, ordering, monitoring and quality assurance; limited schedule for FP at some government health centers that may only have 1 day a week designated for family planning; some community residents live at a distance from services, cost of services and products is too for some community residents; religious barriers, etc.)
- Unaffordable services and products for some community members. (Root causes of performance problem: community/client inability or unwillingness to pay.)
- Lack of sufficient financial resources for and financial sustainability of the sites. (Root causes of performance problem: inadequate government revenue; too little spent on primary health care level; etc.)
- Deficits in quality of care and services provided to family planning. (Root causes: poor physical condition of sites due to insufficient resources; lack of running water and electricity; lack of functioning equipment (sterilizing equipment, microscopes, lamps, etc.); deficits in certain technical areas among providers such as infection prevention and counseling; occasional stock-outs of commodities; in some local government sites visited over-extended nurses providing many different primary health care services including family planning and also managing the site; inefficient and ineffective management practices; poor storage facilities, etc.)
- The providers in both the NGO clinic visited and the LGA health centers lack certain skills and knowledge in areas such as counseling, infection prevention practices, management and MIS (Root causes of performance gaps: no recent training especially in the public sector, no guidelines and standards on site except in one facility.)
- Client dissatisfaction with services. (Root causes of performance gap: physical and material deficits at sites due to lack of resources; lack of more educational materials at sites; lack of privacy again due to infrastructure problems, etc.)
- Performers/employees at clinic do not have full job satisfaction. (Root causes: insufficient pay, inadequate facilities and supplies, lack of staff development/training opportunities, etc.)
- Management systems and processes are inefficient. (Root causes: lack of resources, systems development; management training and support; staff time to dedicate to these functions.)
- Lack of awareness and acceptance of family planning on part of community residents. (Root causes of performance problem: lack of accessibility of some areas where people reside; use of print and electronic media to increase awareness is costly; lack of skilled personnel in IEC activities; problems of staff mobility/transportation to conduct outreach and education; lack of continuity in these efforts; need to craft more linguistically/culturally appropriate, client-friendly messages.)

Provider Desired Performance—Enugu

- Providers attract new family planning clients regularly through outreach and education. Countering rumors/misconceptions about family planning and educating about the importance of family planning or child spacing and maternal, child, and family health.
- Providers offer client-oriented, quality services, practicing infection prevention, comprehensive client counseling and integrated service delivery.
- Providers establish and maintain a 2 way referral system.
- Providers establish and maintain good client records (i.e., service utilization forms, clinical records, other statistics on outreach, referrals and counter-referrals, etc).
- Providers reach opinion leaders, decision makers and community leaders through advocacy and education and also coordinate and network with other organizations that can carry out these tasks.
- Providers correctly use available equipment and drugs.
- Providers screen every client following established, up-to-date standards. Providers counsel clients comprehensively on all available methods.

Provider Actual Performance—Enugu

4. There are few new clients and continuing FP clients at the site. Organization of staff resources (nurses and CHEWs) is sometimes not clear in terms of who does what. Job descriptions do not clarify proportion of time spent seeing patients and proportion of time conducting outreach. There are no goals and objectives for clinic service delivery and outreach. CHEWs presumably are responsible for outreach and education but spend a lot of time attending clients at the site. There are other barriers to outreach including safety issues for staff, skills and knowledge in IEC, lack of transportation, inhospitable community attitudes regarding family planning.
5. Providers are not providing high quality family planning care at the sites visited.
6. Providers lack the inputs (e.g., proper physical infrastructure, clean, painted sites, running water, electricity, functioning bathrooms for clients, functioning equipment, supplies, on-going staff development, sufficient human resources and adequate organization of these resources, on-going facilitative supervision) and basic functioning management systems and processes (e.g., a logistics systems that assures a steady flow of contraceptive commodities and a planning system that establishes and monitors site performance and individual performance objectives, etc.). Although they exhibit basic understanding of infection prevention practices, providers do not practice up-to-date infection prevention. Correct hand washing is not always practiced and there were deficiencies in sterilization and waste disposal procedures.
7. Family planning standards and guidelines were only found in one health center.

8. Clients were not adequately counseled about dual protection, providers sometimes offered information on methods that were not available at the site or were not as reliable as others (e.g. diaphragm) and they did not always practice state-of-the-art FP counseling techniques (e.g., establishing a good client-provider relationship, giving clients an informed choice, exhibiting understanding of local language, establishing trust, etc).
 9. Family planning services are delivered vertically in LGA health centers and there are missed opportunities to promote family planning and increase utilization of Family planning services (e.g., when mothers bring babies and children in for immunizations and not encouraged to stop for Family Planning counseling). When providers live in other communities other than the one where the site is located, they may not always be as available.
- The sites, especially the government facilities, lacked posters and other client information (e.g., posters, etc).
 - Two way referrals: there was no evidence of a two way referral system although providers at the LGA sites and the PPFN clinic made referrals to Park Lane Hospital and the university teaching hospital
 - There is no working management information system. Daily and monthly record keeping is poor. Client records are incomplete, incorrectly completed or unavailable. Consequently it is impossible to monitor and evaluate client characteristics and service utilization. Data are not used for planning purposes, site management or performance monitoring. It was hard to get a full picture of family planning services utilization at sites because frequently sites had data for 4-6 months and not the 11 previous months in 2000 (Jan–Nov, 2000). It was observed that the needed forms were not available.
 - Staff are not reaching enough opinion leaders, decision makers and community leaders and educating about and advocating for FP and also coordinating and networking with organizations that may be able to do this. Overall site priorities and action plans did not exist. Clear role and responsibilities and delegation of authority is lacking. Some staff were overly busy. Others less do.
 - Providers do not always correctly use methods and available equipment, supplies: Providers incorrectly inserted IUDs, it was observed that some standards needed be updated. Infection prevention process were incomplete and incorrect, there is basic understanding of the appropriate procedures but there are not correctly implement as an example: sterilized instruments in boiling water but then left the instruments sitting in the water where they eventually rusted. Hands' washing is inconsistent or impossible for the lack of running water.
 - Providers at the 5 sites visited in Enugu are not conducting comprehensive screening of every client and lack established, up-to-date standards for doing so. They exhibit insufficient knowledge of the need and importance of screening and screening techniques; they followed out of date standards. Various issues were raised regarding this including the quality and content of the information provided to clients, the lack of privacy for clients, lack of client information (e.g., posters), provider appearance and in some cases, provider attitudes toward clients: providers do not counsel clients comprehensively, practicing state-of-the-art counseling

techniques. The quality and content of the information provided on all available FP methods, HIV/AIDs and other STDs, informed choice, etc.) is somewhat deficient.

Provider Performance Gaps—Enugu

- Deficits in outreach to community on FP and RH. (Root causes: staff organization issues such as clear job expectations, job descriptions, performance objectives, workload distribution, lack of motivation and initiative; lack of security and personal safety for staff conducting outreach in communities; inadequate funding for education and outreach efforts; lack of transportation to do outreach; inaccessibility due to bad roads.)
- Quality service delivery is lacking. (Root causes: lack of resources such as water, electricity, sterilization equipment, adequate physical infrastructure; commodity stock-outs; lack of up-to-date knowledge regarding infection prevention practices, counseling, integrated service delivery, up to date services delivery standards, etc.)
- Two way referral system is not well established and functioning. (Root causes: lack of prioritizing the importance of such a referral system and establishing and maintaining it as a component of overall quality care; lack of communications and linkages between facilities; client barriers to accessing referral sites.)
- Poor record keeping. (Root causes: no established and functioning MIS that also includes data for decision making processes linked to planning; no requirements for quality, accurate data collections; no training and system management capacity; low performance expectations in this area.)
- Providers failing to reach and educate decision makers, opinion leaders and community leaders and/or coordinate with other organizations with the capacity to do this. (Root causes: lack of staff time and capacity to carry out this activity, lack of strategic and operational planning, hostile external environment that may not favor openly advocating for family planning/child spacing for religious and cultural reasons.)
- Providers not always correctly using methods, equipment and supplies. (Root causes: lack of training, lack of monitoring and supervision, physical infrastructure inadequacies impede doing this.)
- Lack of state-of-the-art screening. (Root causes: lack of on-going staff training and up-to-date standards and guidelines, lack of supervision and monitoring.)
- Lack of state-of-the-art family planning counseling. (Root causes: lack of staff training and standards and guidelines, lack of on-going supervision and monitoring.)